STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 01 B. WING	06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN46202

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/23/11 Facility Number: 000131 Provider Number: 155226 AIM Number: 100274910 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, North Capitol Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This four story facility was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 123 and had	K0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the credible letter of compliance and requests a Desk review on or after July 10, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	a census of 114 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/27/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 10 doors serving hazardous areas such as storage rooms greater than fifty square feet in size used to store combustible materials and the kitchen are equipped with doors which would automatically close and latch into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity the third floor Dining Room and the kitchen by the Main Dining Room on the first floor.	K0029	**K029** It is the practice of this provider to be in compliance with NFPA 101 Life Safety Code Standard. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: An automatic door closer was installed by the Maintenance Director on July 6, 2011 to the third	07/10/2011

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	Findings include: Based on observations with the Environmental Director during a tour of the facility from 10:55 a.m. to 2:05 p.m. on 06/23/11, the following was observed: a. The third floor Dining Room measured 150 square feet in size, is used to store combustible respiratory therapy supplies and is not equipped with a self closing device on the entry door. b. The kitchen entry door set from the Main Dining Room on the first floor is provided with a self closing device but is not provided with positive latching hardware in order for the door set to latch into the door frame. Based on interview at the time of observation, the Environmental Director acknowledged the third floor Dining Room is greater than fifty square feet is size, is used to store combustible materials and is not equipped with a self closing device on the entry door and the kitchen entry door set is not provided with positive latching hardware. 3.1-19(b)		floor dining room. The kitchen door had positive latching hardware replaced on July 6, 2011. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the alleged practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Doors will be added to the Preventative maintenance rounding sheets. to be used to monitor that applicable doors will operate according to specifications and necessity. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Preventative maintenance rounding sheets will be used to monitor that applicable doors will operate according to specifications and necessity. Monitoring will be done by the maintenance director or designee until threshold is met.	

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K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.			
	Based on interview and record review, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of electrical power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Exercise - Weekly/Monthly Test Log" documentation with the Environmental Director from 8:50 a.m. to 10:55 a.m. on 06/23/11, monthly load tests are documented on the weekly/monthly test log for the period 05/06/10 through 06/16/11 but each monthly load test record lists "30	K0144	K144 It is the practice of this provider that generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Generator transfer time test done during survey with less than a 2 second delay to transfer power. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the alleged practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Maintenance Director will exercise a load test monthly and properly record the load transfer time. How the corrective action(s) will be monitored to ensure the deficient	07/10/2011

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	Minutes" as the time to transfer building power to the emergency generator. Based on interview at the time of record review, the Environmental Director acknowledged the entry for the time to transfer building power to the emergency generator on each monthly load testing record was the time the generator ran during the load test and not the time to transfer building power to the emergency generator. 3.1-19(b)		practice will not recur: Monitoring will be done monthly by the maintenance director or designee until threshold is met.	